the tissues, over and around Poupart's ligaments, seemed like a mass of hardened cellular tissue, tightly strung across from iliac crest to pubes, and without the appearance of a gland or other vessel to allow circulation of any kind to take place. The deep-seated bloodvessels, nerves, etc., beneath this ligament, did not seem in any way affected; indeed, the peculiarity of this case, which appeared at the time most striking, was the want of anastomotic connection between the external and internal lymphatics.

Dr. Paterson has not been able to find any case on record exactly resembling this one. The cases which most nearly resemble it differ, however, in so far that the dilated lymphatic vessels of this case appeared on the surface of the extremity, and could not be traced in any way as connected with any lesion of the bloodvessels or absorbent system of the deeper-seated organs; in fact, the case seemed to turn upon the point whether or not there was sufficient anastomosis between the external and internal system of absorbents. I now regret much that the thoracic duct and other organs within the abdomen were not examined.

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39. *Treatment of Otorrhœa by Spirit of Wine.*—Dr. F. E Weber, in continuation of a former paper on this subject, states (*Berlin. Klin. Woch.*, Jan. 9), that often-repeated experience enables him to state that in otorrhœa, unconnected with caries or polypous growth, spirit of wine constitutes the best topical application, and one that is highly efficacious when there is chronic inflammations of the cavity of the tympanum, with more or less destruction of the membrana. The spirit must be quite pure, highly rectified, and undiluted with water, and its application to the exposed membrane of the tympanum causes no pain, being in this respect, also, a preferable application to most other injections. In some sensitive subjects it produces a burning sensation, which passes off in less than a minute. Before applying the spirit, the ear must be carefully cleaned out by means of the syringe, air-douche, or pencil, when, the patient lying down, as much of it as the ear will hold must be poured in, and retained during five minutes, slight pressure and rubbing of the tragus being employed to assist its effectual penetration. After the spirit has been allowed to flow out again, the meatus must be thoroughly dried and plugged, so as to prevent the access of air. At first it should be applied three times a day, and afterwards twice, continuing it for some time after the otorrhœa has ceased.—*Med. Times and Gaz.*, Feb. 25, 1871.

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40. *Skin-Grafting.*—Dr. David Page, as the result of microscopic investigation into this subject, has arrived at the conclusion that "when a piece of the integument is removed from a part of the body, and placed upon the surface of an ulcer showing a disposition to heal, there was no transplantation of cutis, but of cuticle, the deeper layer of which, or *rete mucosum*, formed the essential portion for subsequent development and growth; and the young newly formed cells of this layer served as the basis for the production of cicatrix. Further, I found that the artificially induced cicatrix, and that which was spontaneously projected from the margin of the ulcer, were identical in structure, and equally possessing the same low vitality and tendency to destruction, from causes that could not affect the normal integument. These results proved satisfactorily that the *rete mucosum* or *stratum Malpighii* was the part immediately concerned in the process; and that a graft, to be successful, need consist of this layer only. I held, therefore, the view that it is not a transplantation of skin, but of epithelium; not skin-grafting, but epithelium-grafting.

"The advantages sought for in skin-grafting are," he says, "threefold, viz: 1. Rapidity of cicatrization; 2. Formation of an elastic and durable cicatrix; 3. Prevention of excessive contraction of surrounding textures, and subsequent deformity.

With regard to the first of these, it is necessary that the ulcer should be in a perfectly healthy and healing condition, as evinced by the vascularity of its edges and vigour of the granulations on its surface. Hence, the weak and indolent, and callous ulcer must first undergo the usual means of treatment to bring them into this state. In every case where a graft has been transplanted upon an unhealthy or weak ulcer, the result has been failure.

The formation of a cicatrix of greater durability and elasticity than that spontaneously formed, is an advantage which has been misconceived, and cannot, I think, be actually attained. To replace effectually the lost integument over a broken surface, nothing short of a true plastic operation would avail, such as the Taliacotian and other modes of restoring defects of the nose and lips, wherein a flap embracing the entire thickness of the cutis vera, with its vascular supply, is only partially raised and removed. One thing must be borne in mind in estimating the value of a new formation such as a cicatrix; and that is, that it is the result of rapid cell-development and growth, the final effort on the part of living textures to close over a breach of surface that has contracted to the utmost of the laxity of neighbouring parts. Now, it happens that both the cicatrices formed by an ulcer healed by the assistance of skin-grafting are identical, and equally devoid of an approach in quality or structure to true skin. The fibro-vascular or deep-layer of the cutis, with the hair follicles, sebaceous, and sweat-glands, if destroyed, cannot be regenerated; but the papillary layer, excepting those pupils of special sense containing the terminal twigs of the sensory nerves, is probably represented in the cicatrix, although it is also true that the latter never attains the same degree of versatility, and, as a consequence, is of much lower vitality, as shown in the manner in which old cicatrices give way under cachectic states of the system.

As for the prevention of deformity and excessive contraction of neighbouring parts, this must depend upon the original extent of the ulcer and the position in which it occurs; the less good can be effected by skin-grafting in this respect in proportion to the amount of tissue destroyed and laxity of the textures around. Take, for example, a burn of the soft parts; it is well known that deep-seated contraction, leading often to irremediable deformity, goes on for some time after the surface has cicatrized; and how more rapidity, in the latter respect, effected by the adventitious aid of skin-grafting, could obviate these disastrous results, I am at a loss to comprehend. The only advantages, then, of skin-grafting. I must contend to be acceleration of cicatricial growth."

The following is Dr. Page's method of operating: "The most convenient source for the grafts is the skin over the biceps muscle of the arm. This should be gently pinched up by dressing forceps, and then cut off by a stroke of the scissors. The thickness of the cuticle varies in different parts of the body; but, as I hold it essential not only to avoid the subcutaneous textures, but the cutis itself, the graft should be removed without any bleeding, if possible—an occurrence which would show that the papillary layer of the cutis, at any rate, had been reached. The size of the elliptical piece of cuticle thus removed, should not exceed a quarter of an inch in diameter. The graft is then simply placed upon the surface of the granulations, which it is quite unnecessary to irritate or disturb in any way; and the site chosen should be that where new growth is most desirable. To retain the graft in position, I have used strips of isinglass plaster placed over the surface of the ulcer, and carried partly around the limb. The ordinary dressings may then be applied, and the parts treated in the ordinary way, with systematic bandaging and rest. The progress of the graft may be observed three or four days later, carefully raising the strip of plaster; and in a period varying from that time to a week or so, growth begins. The superficial and older layer of the epidermis has then desquamated, and will be found lying loose on the surface, while the deep layer of the rete mucosum is left adherent to the granulations, forming a delicate pellicle of a bluish tint. Henceforward, from day to day, as the dressings of the ulcer are renewed, and the progress of the graft seen, its area grows larger and larger by cell-development at the periphery, probably, too, accompanied by coincident increase of growth from the margin of the ulcer, which seems to receive a fresh stimulus from the presence of the graft. Ultimately, the surface will close over, and present the ordinary appearance of a cicatrix. Why transplanted epithelium should lead to the development of its elements, while the granulations themselves appear to be incapable of setting up similar points of cicatrization spontaneously over the surface, and growth, under ordinary circumstances, only proceeds from the margins, is difficult to understand. Nevertheless, it is a well ascertained fact. Nor does the transplanted epithelium afford a mere point of attachment for such a spontaneous formation; as experiments with pieces of India-rubber and sheepskin, substituted for skin-grafts, showed that these only acted as foreign matters, causing destruction of the granulations on which they lay."—*British Med. Journ.*, May 27, 1871.

OPHTHALMOLOGY.

41. *Dermoid Tumour of Cornea.*—Mr. H. Rosborough Swanzy presented to the Pathological Society of Dublin (*Brit. Med. Journal*, April 22, 1871) the drawing of a dermoid tumour of the cornea, which he had observed at the clinique of the late Professor von Graefe. The swelling was congenital, and consisted of two segments connected by a narrow band. The anterior segment was about the size of a large cherry, and the posterior one less than half that size. This was probably the largest dermoid tumour of the cornea that had been described. It was likely that the peculiar shape of the growth had been determined by the constriction to which it must have been subjected by the eyelids *in utero*. The base of the posterior segment covered the whole cornea with the exception of a small portion, a line in width, at the inside. The tumour was removed by Professor von Graefe, and an aperture in the globe was left where the base of the tumour had been situated. Through this opening a considerable portion of the vitreous body escaped, but no crystalline lens could be found. The latter must, therefore, have been congenitally deficient. Microscopically, the tumour consisted of all the elements, more or less developed, of true skin —hair-follicles, papillæ, etc. Its main bulk was composed of adipose tissue, corresponding to the usual subcutaneous fat. Mr. Swanzy suggested that this growth might perhaps have had its origin in an arrested, or diverted, development of the crystalline lens, which we know takes place by the inversion and invagination of a portion of the cuticle in a depression of the primary optic vesicle.

For a full report of this case the reader is referred to the *Dublin Quarterly Journal of Medical Science* for May, 1871, p. 295.

42. *Diagnosis of Intraocular Sarcoma.*—Dr. O. Becker (*Arch. f. Augen.- und Ohrenheilk.* 1870, 1, 2) remarks that Von Gräfe was the first to point out the fact that, in its first stages, the existence of sarcoma of the choroid coat of the eye is liable to escape observation, on account of the separation of the retina by pressure from within. Such is not the case, however, when the swelling proceeds from the ciliary body, as the intimate connection of this with the ciliary portion of the retina does not allow of the separation of the latter; as slight, also, Dr. B. found the separation of the retina to take place when the sarcoma of the choroid coat develops itself in the vicinity of the *macula lutea*. It has, also, a far less disposition to press itself downwards, towards the interior of the eyeball, but develops itself extra-bulbar towards the back part of the orbit. In three cases where the tumour was thus seated, there was no detachment of the retina during at least the first period of the disease, and even at a period of such a development of the tumour, probably when it had already caused a disturbance of the power of vision of the eye. The form of the tumour, also, was not roundish as usual, but flatter, acquiring only gradually a greater degree of thickness. When the tumour is otherwise seated, there may take place no separation of the retina, or only to a slight degree, insufficient to prevent the presence of the tumour from being detected. If the tumour be seated within the upper part of the eye, the fluid collected between it and the retina forms a kind of pouch around the tumour. If there is only a small collection of fluid, the tumour through it can be seen, or the pouch representing the form of the tumour; in this manner the case can be distinguished from one of mere separation of the retina. If, however, the